European Journal of Oncology Nursing 48 (2020) 101792

Contents lists available at ScienceDirect

European Journal of Oncology Nursing

journal homepage: www.elsevier.com/locate/ejon

Nurses' response to spiritual needs of cancer patients

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ARTICLE INFO

Keywords:
Cancer
Palliative care
End of life
Quality of life
Spirituality
Spiritual care
Spiritual needs
Spiritual assessment
Psychosocial care
Religious concerns
Religion

ABSTRACT

Purpose: In this qualitative study, nurses from the United States of America (USA) and Switzerland were asked to recount their spiritual care experiences with cancer patients and their own responses to their patients' spiritual needs. Recent advances in cancer care have highlighted the importance of spirituality and spiritual care as part of quality palliative care from the time of a patient's diagnosis through end of life. Nurses who play an important role in supporting patients, describe their own discomfort when confronting their patients' spiritual needs.

Methods: A qualitative survey was used to collect narratives of nurses' experiences in responding to spiritual care needs (n = 62). The accounts were analyzed using thematic analysis.

Results: Nurses identified patients as having spiritual needs and their own experiences in addressing spirituality or religion. Patients sought meaning in their illness, which, they believed, led to disease acceptance. Nurses reported their patients' struggles with challenging disease situations and their own challenges in addressing patients' spirituality/religion. With experience, nurses developed ways of talking with patients about spirituality/religion, which profoundly impacted their own lives and resulted in personal growth.

Conclusion: Patients' spirituality was identified by nurses who tried to address patients' spiritual needs drawing on existing resources. For nurses, supporting patients in their spirituality and finding meaning in the disease situation eventually led to disease acceptance.

1. Introduction

Spirituality is multidimensional and complex, and influences how patients cope with serious illness and how they transition across the cancer continuum (Balboni et al., 2017; Puchalski et al., 2019b). Diverse definitions of spirituality exist and most of these refer to the connection to the inner self, to nature or existential concerns (Monareng, 2012; Pesut, 2010; Weathers et al., 2016). Religion includes beliefs in God or of higher being and a faith community (Edwards et al., 2010; McSherry and Cash, 2004). Recent literature defines spirituality as inclusive of religious as well as non-religious factors including existential concerns (Puchalski et al., 2014; Steinhauser et al., 2017). Spiritual beliefs affect how individuals face a cancer diagnosis, both for those in long-term survivorship or those facing their own mortality (Economou, 2018; Ferrell and Paice, 2019; Piderman et al., 2015). Patients may experience spiritual distress at the point of diagnosis, as their disease progresses, and when they face their own mortality (Delgado-Guay et al., 2016). Evidence has shown that in terminal illness, patients' spirituality affects all aspects of their life, such as their attitude toward the disease (Wang et al., 2017). However, there is considerable debate on the appropriate timing and process of addressing and supporting patients' spiritual or religious issues, for what purpose and by which professionals (Economou, 2018; Puchalski et al., 2019b; Zumstein-Shaha and Alder, 2018).

Recognized as one of the eight domains of quality palliative care (National Consensus Project for Quality Palliative Care, 2018) spiritual care is essential in oncology to improve quality of life (QOL) during serious illness and constitutes a key element of quality patient-centered care. Spiritual care can help cancer patients find meaning and purpose; maintain hope; manage symptoms; and connect to "self, others, and/or a higher power or nature" during the course of their illness (Phelps et al., 2012; Taylor, 2019). The focus on spiritual care began in hospice and end-of-life care but there is significant recognition in recent years that spiritual care applies across populations and throughout the trajectory of disease (Edwards et al., 2010; Ferrell et al., 2016; Zumstein-Shaha and Alder, 2018). Numerous studies and publications have emphasized the importance of spiritual assessment in order to identify religious affiliations, spiritual strengths, and potential sources of spiritual distress (Ferrell and Paice, 2019; Giske and Cone, 2015; Jim et al., 2015; Moosavi et al., 2019; Phelps et al., 2012; Piderman et al., 2015;

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https://doi.org/10.1016/j.ejon.2020.101792
Received 11 April 2020; Received in revised form 12 June 2020; Accepted 15 June 2020
Available online 17 August 2020
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source: https://doi.org/10.24451/arbor.13454 | downloaded: 4.5.2023

Taylor, 2019). Additional sources have moved beyond assessment of spiritual needs to address spiritual care interventions by interdisciplinary teams and in collaboration with faith communities (Fitchett et al., 2015; Puchalski et al., 2019a; Rosa, 2019; Siler et al., 2019). This latter area of spiritual care has received greater recognition as the populations in the USA and Switzerland become more diverse and nurses recognize the need for culturally respectful care (Epstein-Peterson et al., 2015).

Many spiritual care studies have focused on patients with cancer, cancer survivors and those at the end of life as well as their family caregivers (Epstein-Peterson et al., 2015; Jim et al., 2015; Piderman et al., 2015; Salsman et al., 2015; Sherman et al., 2015; Stephenson and Berry, 2015; Zollfrank et al., 2015). Spirituality is important for those beyond treatment, i.e., cancer survivors, as they often face issues of spirituality after a life-threatening illness (Ferrell et al., 2016; Puchalski et al., 2018). Researchers have noted the relationship of spiritual care within overall psychosocial care, for example through inclusion of spirituality as a component of distress management (Delgado-Guay et al., 2016; Phelps et al., 2012; Wang et al., 2017). Addressing unresolved spiritual distress at the end of life, addressing issues of forgiveness and end of life rituals have been found to be important (Ferrell et al., 2016; Puchalski et al., 2018; Zollfrank et al., 2015). The National Consensus Project for Quality Palliative Care (2018) promotes spiritual care as an important aspect of all care for serious illness, including cancer and end-of-life care. Emerging from many national and international efforts to increase spiritual care education in medical schools, an interprofessional curriculum on spiritual care has been developed and implemented (Puchalski et al., 2019a, 2019b). This curriculum addresses the role of all professionals, including nurses, in spiritual assessment and intervention as well as addressing the spirituality and respective education of health care professionals (Puchalski et al., 2019b; Siler et al., 2019).

Nurses play a significant role in assessing and attending to spiritual needs, as they support patients and families throughout the trajectory of a cancer diagnosis, treatment, and transition to end of life (Giske and Cone, 2015; Taylor, 2019). However, nurses feel insufficiently trained in spiritual care and perceive spiritual care to be the domain of the clergy or other spiritual care professionals. Nurses describe feeling uncomfortable when discussing spiritual or religious beliefs (Phelps et al., 2012). Most professionals, including nurses, are not well prepared to assess or respond to spiritual needs (Balboni et al., 2013, 2014; Wittenberg et al., 2017) and nursing education has not prepared nurses sufficiently (Bennett and Thompson, 2015; Zollfrank et al., 2015). Spiritual assessment tools are now tested to facilitate efficient identification of needs and communication of spiritual issues between team members (Benito et al., 2014; Skalla and Ferrell, 2015; Taylor, 2019). Interventions to meet spiritual needs, particularly within the broad context of existential concerns, have included dignity therapy and other approaches to support patients in finding meaning in illness, conduct life reviews, and find purpose in life amidst disease (Fitchett et al., 2015; Giske and Cone, 2015; Wang et al., 2017).

The aim of this qualitative study was to explore nurses' recounting of patients' spiritual needs. Nurses were asked to describe how they and their colleagues responded to patients' spiritual needs. Understanding how nurses perceive patients' spirituality and spiritual needs including purpose and meaning in life, and concerns about death are l important aspects of delivering spiritual care. Adapting assessment tools and interventions to respond to patients' expressed concerns enables nurses to meet patients' and caregivers' spiritual needs in diverse clinical and cultural settings.

2. Methods

For this study, a qualitative survey was distributed in two countries, the USA and Switzerland. The survey approach was selected in order to obtain narratives and provide anonymity. Narratives are a method to elicit stories and insights about a specific situation and the respondents' role within that situation (McCance et al., 2001). The survey was distributed to nurses attending an End-of-Life Nursing Educational Consortium (ELNEC) Summit held in San Diego, California on July 30–31, 2019 as well as to nurse practitioner students attending the first nurse practitioner Master of Science in nursing program at the Bern University of Applied Sciences (BUAS). The responses of the American participants were collated at the City of Hope Nursing Research and Education Division, whereas the Swiss responses were collated at BUAS Division of Nursing.

The survey consisted of two main questions; the first question asked nurses for stories of patients' spirituality at the beginning of their cancer journey. The second question asked nurses to share their experiences with patients' spirituality and their own responses to this spirituality. Socio-demographic information was elicited from the responding nurses about their age, gender, and the number of years they had been practicing. All data was obtained in a deidentified manner.

Returned responses were collated in a WORD document and subsequently treated using the three-step thematic analysis as described by Tuckett (2005). With this analytic procedure, it is possible to consider phrases and sentences individually (see Tables 1 and 2).

The survey was conducted in accordance with the 1964 Helsinki Declaration and its later amendments. In the USA and Switzerland, surveys involving health professional written surveys are exempt from approval from ethics committees. Participants were informed that the surveys were anonymous, and it was indicated that the survey data could be used in this study. In Switzerland, the study was conducted along the recommendations of the Human Research Act (HRA) (Swiss Confederation, 2011), and the head of the Master of Science in Nursing program allowed for this study to be conducted. Each participant was informed by a short note at the outset of the survey and assured of confidentiality and anonymity.

3. Results

In the USA, a total of 90 surveys were distributed with 58 returned and in Switzerland 4 of 14 surveys were returned by participants, all of whom were registered nurses.

Analysis yielded two main themes: "Trying to make sense of the situation" and "Listening and acknowledging", which are presented below.

Table 1
Thematic analysis by Tuckett (2005).

Step 1	Reading the text thoroughly and annotating it in the margins	• Each transcript is read in detail, • Annotations are entered highlighting relevant passages.
Step 2	Coding the text, writing first results and theorizing	• Each transcript is reread, • Codes are added based on the annotations from step 1, • First results are written up based on the codes.
Step 3	Developing themes	• The results are reconsidered, the transcripts revisited, codes are adjusted, • Themes are developed based on these insights and on the results from step 2, • The results are finalized.

Table 2
Overview of demographic survey information.

Total responses	62 surveys (58 surveys from the USA, 4 surveys from Switzerland)
Participants	34 women, 22 men, but not all participants identified their gender
Age in years	26-74 (mean 37.62)
Education	13% baccalaureate degree 68% Master's degree 18% doctoral education
Numbers of years in nursing	3-47 (mean: 17.86)
General views on spirituality and religion	5 stories
New cancer diagnosis	8 stories
Disease progression	20 stories
End-of-life situations	29 stories

3.1. Trying to make sense of the situation

In this theme, the nurses' perspectives of patients' experiences were summarized with a total of four subthemes: the use of spirituality/religion and rituals, struggling with the disease, finding meaning, and acceptance of the disease.

3.1.1. Use of religion/spirituality or rituals

Patients turned to spirituality and/or religion and/or spirituality due to their disease. Terms such as God or Lord were used, as patients called out to God or engaged in reading scripture, praying, or rituals such as baptism or anointment. In one account, the nurse reported: *"We talked about what was important in her life. She said it was her family and faith in God."*

Patients expressed trust and a belief in God or a higher power, stating that God would heal them. Spiritual beliefs provided patients with a positive outlook and led them to expect better outcomes. Some patients explained good results as coming from God's power and His concern for the individual. Patients even maintained that God would not allow their life to end. A nurse reported: *"[T]he Lord simply would not just take him away from his young family."*

Similarly, disease progression, changes in health and treatment plan were also explained as times when there was trust in God. An example was, *"Patient started treatment but opted not to take any more treatments. Left her life in God's hands."* For these patients, spiritual or religious beliefs, including faith-related activities were a source of support providing greater strength to face the disease.

There were moments when patients asked nurses to pray with them. Some patients requested specific faith-related rituals be observed at death: *"She [the patient] wished to have some Jewish aspects of her death and [also her] Buddhism."* In one of the narratives, a nurse observed the decision-making of a family regarding the burying ritual. The patient had expressed a wish that a faith-related burial tradition be observed, and nurses involved in the patient's care worked to honor the patient's last wish.

In some instances, the patients' relationships with their faith community provided important support. Patients would ask their faith community to pray for them, and nurses supported patients' desires to integrate the faith community in their care.

3.1.2. Struggling with the disease

Frequently, patients blamed God for their illness. Many patients were angry or experienced despair. They grappled with the challenges of the disease, becoming depressed and experiencing spiritual upheavals. One account depicted a patient's desperation and sadness: *"She [the patient] sensed that her time was running out and she cried for her children."* Some narratives were about young patients. For these patients, life was over before it had begun. There were feelings of hopelessness and uncertainty, fear of dying, and worry of suffering. Many patients cried and some would continue to struggle until their death. It was particularly challenging for patients to come to terms with their disease, when they did not feel ill.

For some patients, spirituality or religion provided a rationale for not taking medications or continuing treatment. In one account, the nurse reported that the *"Patient finally told me [the nurse] that she was fasting for a Caribbean religious festival and had not been compliant with her meds due to fasting restrictions."* In other cases, religious beliefs were in opposition to nurses' recommendations for the best, evidence-based treatments. Nurses described questions about the potential success of the treatments and certain life-prolonging treatments that arose in the context of family members' religious beliefs.

3.1.3. Finding meaning

Many patients asked the "why-question": *"Why does this happen?"* They reasoned that they had lived life normally, had not smoked too much or had not lived a sedentary life. Patients sought to understand the reasons for falling ill or to find a way of dealing with the disease in order to make sense of their lives and illness before death.

Some patients stated that they were *"more than my cancer."* They did not want to die from the cancer, which became a purpose in their lives. Finding life's purpose such as getting through the chemotherapy was important. There were patients who saw work as their main purpose, which could then be used as an excuse not to adhere to treatment schedules.

Other patients prioritized their personal and family life as their main purpose, wanting to protect their family members and have more time with them. In one story, a woman's purpose was to marry before she died. It took considerable effort to make the marriage happen. The patient was able to marry and had some quality time with her husband before she died.

Yet other patients wanted to have time for their pets, a project, or to participate in activities such as sports. In one of the stories, a patient's horse had just given birth to a colt. It was the patient's strong desire to see the colt before dying. Other patients wanted to see their friends one last time, although this was often exhausting. In some cases, patients interacted with other patients and had meaningful conversations about their shared experiences. For many patients, it was important to *"give back"* by engaging in community or charitable work.

Some stories related the *"bumpy road"* to finding meaning in life. One patient believed he had failed his family and had not been the person they had expected. Other patients engaged in discussions with nurses about God. Some of the patients were quite clear about how they believed there was life after death, while others stated that nothing existed beyond death.

3.1.4. Acceptance of the disease

Overall, patients tried to remain independent in the course of their illness journey, while trying to respect the wishes of families and friends. Eventually, patients were described as finding a way to accept that their death was inevitable. In one of the stories, a close family member reported to the nurses *"that if Allah wanted to take her, He would … and this is just a fact of life."*

Spirituality was one factor that helped some patients accept their disease. It provided hope to continue treatment, while others' prayers supported patients and families experiencing the illness. Families also relied on spirituality in reaching acceptance of their respective member's disease and in preparing for the difficult times ahead.

For many patients in this study, it was important to die in peace. They worked hard to reconcile with family members. Patients who had succeeded in obtaining peace were calm and ready to die. They were ready to change their goals of care from disease-focused treatment to comfort care. The patients' sense of peace was evident. Some of these patients mentioned an afterlife as they described their acceptance of death. They believed there was something waiting for them after death. There was one account where the patient stated that she was *"going*

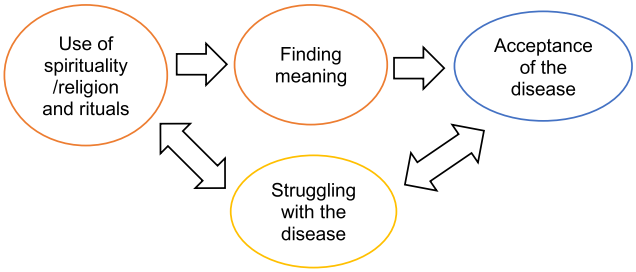

Fig. 1. Patients and spirituality according to nurses.

somewhere great." For some families, this acceptance was a means to prepare their home for the patient and his/her eventual death at home.

The following model summarizes the patient-related findings (Fig. 1).

In the theme of "Trying to make sense of the situation", nurses reported that patients turn to spirituality and/or religion and related rituals as a result of a cancer diagnosis. Patients struggled to determine the purpose of life and to find meaning in the disease. For other patients, illness and difficult treatment regimens challenged the process of meaning making. For the nurses, it appeared that patients aimed at acceptance of the disease and its impact on life. Patients used the terms "spirituality and religion" or "faith" interchangeably. Nurses described the patients' difficulty in finding meaning and peace as part of the spiritual care they tried to provide. It was important that nurses listened, engaged, and responded to a patient's spiritual needs.

3.2. Listening and acknowledging

In this theme, the nurses expressed four subthemes: the challenge of addressing spirituality and religion, finding a way to talk about spirituality and religion, providing spiritual care, and personal reflections on spirituality.

3.2.1. Challenge of addressing spirituality and/or religion

Nurses acknowledged that it can be difficult to talk about religious and spiritual issues with patients, especially since this is not part of routine care and is not performed regularly. In one account, a nurse stated: *"Unfortunately, spirituality is never asked about,"* with some nurses indicating that neither religion nor spirituality were considered important issues within their institutions. Nurses would ask about psychological issues instead: *"So many times, I asked her [the patient] if she needed any psychological* support*."*

Nurses often used a patient's religion as a starting point. One nurse stated: *"It was very evident that she [the patient] was a highly spiritual being. She quoted many scriptures to me."* Based on recognition of religious affiliations, nurses could further explore spirituality, to determine if patients accepted their disease and were at peace with impending death.

Some nurses acknowledged that their own lack of confidence in discussing spirituality or religion contributed to a hesitancy to engage in spiritual care. *"We, in oncology, did not respond well to her spiritual needs."* For some nurses, all things pertaining to spirituality and religion were "private matters".

Other nurses reported difficulties in identifying the appropriate, well-trained professional such as a chaplain who could respond to their patients' religious or spiritual needs. Shortcomings of the respective organization or institution were identified as obstacles, as the following quote demonstrates: *"Part of the struggle in my job is the locating and figuring out who to contact for help with those spiritual needs. The effort to meet those are there but finding how to meet them is the struggle."* In other instances, nurses highlighted patients' avoidance of spiritual or religious issues which nurses perceived as challenging.

"I tried to talk with her about this, but she was completely unable to recognize this (…) She continued to try alternative treatments and ignore her faith and to continue to blame the health care system."

There were accounts indicating that a patient's spirituality or religion could complicate treatment. Nurses reported that some patients used religion, faith, or spirituality to explain their disease and its consequences or as a reason to refuse treatment. When this happened, nurses reported their frustrations and feelings of helplessness. There were *"Frequent discussions with the doctor and some staff. Mostly staff was concerned but frustrated."*

3.2.2. Finding a way to talk about spirituality/religion

Nurses expressed the value of facilitating conversations about spirituality was considered important. Often these discussions about spirituality and about the disease helped patients accept the transitory nature of life and death: *"He knew he was dying and was terribly concerned about his family. We were able to discuss his concerns. After his death I was able to share this conversation with his parents [and they] were so grateful."*

Nurses who were trained to address spiritual and religious issues did so more regularly. One nurse reported: *"We regularly sought talks with him, we kept asking him if he needed some professional guidance or* support *in this difficult moment. He would every time politely decline."* Some of the nurses used body language to emphasize the meaning of their words: *"I ask how they are doing inside or 'in here' and touch my chest or if there are any thoughts or beliefs that bring them comfort. 'What is it that brings you comfort through this difficult time? Do you consider yourself a religious or spiritual person? How does your religion/spirituality impact your QOL? or illness?'."* Some nurses would ask: *"How are you feeling?"* or *"What has changed?"* Regardless of differing perspectives, nurses report being able to maintain their interest in patients' spiritual and religious issues; for example, *"[I] respected her view even though I am Christian."*

Another way of addressing spiritual and religious issues was to listen to patients more closely. Nurses reported that they *"acknowledged"* the patients' beliefs or anger. They provided time for patients to talk about their feelings. Such conversations were aimed at reassuring the patients. Through these strategies, listening, being present, acknowledging, nurses were able to *"evaluate their [the patients'] belief systems."* However, it was important for nurses to have time for such conversations about patients' beliefs. When this was possible, nurses reported that the outcome was very rewarding as demonstrated in the following account: *"Everyone gave me the time to do this – picked up my other patients so I could focus only on this family. Wonderful outcome."*

3.2.3. Providing spiritual care

Nurses tried to support patients in exercising their religious and spiritual beliefs. It was important to show respect towards patients for how they chose to deal with their individual situations. Many different forms of spiritual care were reported. These ranged from engaging personally as nurses with patients or their families in exercising spiritual care practices such as reading a specific piece of scripture, to calling in spiritual care providers from the respective faith community or denomination. Many nurses mentioned that they verbally or nonverbally indicated their respect for their patient's connection with God or another higher power. When patients asked to exercise their religious faith-based practices, nurses were generally supportive. In these instances, nurses called for representatives of the respective faith community or arranged time for the patient to pray or engage in faith or ritual practices. It was important for nurses to discuss ways of implementing the exercise of faith-based practices with patients and to put these plans into action. Occasionally, nurses used the patients' religious and spiritual connections and attitudes to promote coping: *"I reminded him that he should not lose faith … that it was his faith that had taken him this far."*

Many nurses reported that they engaged in prayers with the patients as sometimes, patients would ask nurses to pray with them. In other

situations, the nurses would suggest this practice, as the following narrative highlighted: *"After some time of listening and dialogue, I prayed with her."* Other ways for nurses to support patients' spirituality were to sit with patients, meditate, recall memories together, or talk with patients without attempting to answer questions. It was then possible for patients to talk about their anger and despair. Other nurses talked with patients about their feelings and emotions or discussed preparations for end of life. When specific wishes were mentioned in the narratives of patients and their families, nurses reported their active support such as organizing the discharge from the hospital or arranging for these wishes to be fulfilled: *"They (the parents) were afraid to go home and not being present when the newborn infant would die. Therefore, we put together two big patient beds. The parents stayed and slept by their baby, the baby between the parents' beds."* For some nurses, it was important to engage faith-community representatives as soon as possible. They would encourage patients or their families to call their respective representative.

Many nurses reinforced the importance of listening. According to the nurses, spiritual care started and ended with actively listening to patients as the following account illustrates: *"Anything is possible if the hospice nurse listens to the patient's wishes and collaborates with family/friends."*

In these examples, it was essential for nurses to provide support, to demonstrate respect and appreciation. Nurses noted that these spiritual care practices reduced patients' anxiety and reinforced calm and peace.

3.2.4. Personal reflections on spirituality/religion

Reflecting on religion and spirituality and engaging in spiritual care did affect the nurses, as they reported that they had been personally touched by specific situations: "I remain touched by her to this day." The peace patients obtained was compensation: *"Her peace gave us both peace. It was such a privilege to be able to facilitate that important conversation."* Such situations led nurses to reflect on their work. They thought about improving their work in the future.

> *"Listening and then reflecting. I offered chaplain support and she [patient] declined. In hindsight I could have presented it differently and will going forward."*

Nurses concluded that religious, faith, and spiritual issues were important. They need to be addressed. Based on their experiences, some nurses resolved to ask about these issues sooner in the care process. Other nurses maintained the importance of asking about religious, faith, or spiritual issues throughout the care process.

The following model summarizes the nurses' perspective of religious and spiritual issues (Fig. 2):

4. Discussion

Findings from this study suggest that in facing the disease, patients often turn to their religion/spirituality to find meaning. Patients use the terms religion or spirituality to indicate their needs. Spiritual distress in patients can have a significant impact on the patient's quality of life

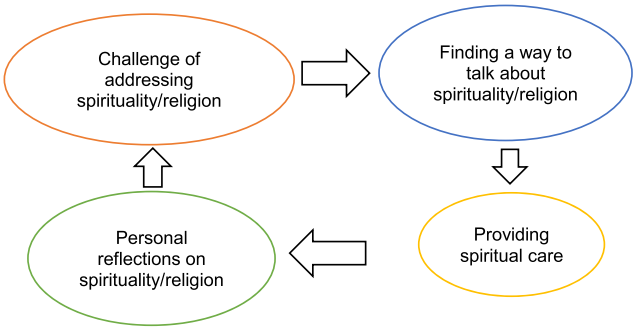

Fig. 2. Nurses responses to patients' spirituality.

(Ferrell and Paice, 2019; Taylor, 2019; Zumstein-Shaha and Alder, 2018). Listening to patients' questions related to "why me" statements or anger at God or others can help nurses understand their religious struggles, fear of lack of control, or need to find meaning and purpose before the end of their lives. In addition, by listening to the patients' wording, nurses and other clinicians will find a way to discuss these issues (Epstein-Peterson et al., 2015; Jim et al., 2015).

Nurses expressed an awareness of the importance of spirituality, yet many stated they found it difficult or uncomfortable to talk to patients about spirituality or to encourage patients to share their spirituality. They felt a lack of spiritual competency, particularly in finding the right words, and were hesitant to assess patients out of a concern that they would not be able to respond to their needs. Some nurses expressed their opinion that religion/spirituality is a private matter. Nurses' lack of confidence in addressing the religious and spiritual needs of patients has been documented and is present in the nurses' response to this survey (Moosavi et al., 2019; Phelps et al., 2012; Skalla and Ferrell, 2015).

This study revealed the need for training on the importance of spiritual care as an essential element in quality of life care. Nurses who are specifically trained in spiritual and religious issues are reported to be more likely to incorporate spiritual assessment into their practice (Taylor, 2019; Zumstein-Shaha and Alder, 2018). Educating nurses and healthcare providers about offering spiritual care increased their respective use of spiritual practice by 33%. In addition, comfort with speaking about spiritual care also grew by 29%. Most notably, the frequency of including religious or spiritual care in nursing practice increased by 75% (Zollfrank et al., 2015). Equipping nurses through education and as early on as in their respective professional training in spiritual assessment and seeking appropriate spiritual representatives for the respective faith communities could reduce the barriers and improve nurses' confidence and competence in providing spiritual/religious care to their patients and families (Balboni et al., 2013, 2014).

Nurses also need to be trained to provide culturally sensitive care and be attentive to patients' ways of expression. A lack of spiritual sensitivity in the healthcare setting remains a barrier to providing culturally sensitive care and responding to patients' spiritual needs (Moosavi et al., 2019). Nurses should strive to acknowledge spiritual and religious needs of patients and caregivers from culturally diverse backgrounds. Using the spiritual beliefs of patients to reinforce what the patient and family believe or have described as most meaningful to them, can help reduce anxiety and reinforce a sense of calm and peace. However, nurses need to be aware of their personal spirituality, so that they refrain from imposing their own beliefs, practices, or worldview on their patients. Recognizing how nurses' personal spirituality impacts their ability to assess and support the patients' spiritual needs is essential (Taylor et al., 2014).

Some nurses expressed that listening and being present with their patients was important, while others engaged in prayer with or expressed their support for their patients' spirituality. Spiritual care practices described in nursing predominantly involve religious practices such as prayer (Epstein-Peterson et al., 2015). Practices such as listening or sitting with patients in difficult situations are not necessarily considered spiritual care. However, these latter practices are essential to the nurses' toolbox (Zumstein-Shaha and Alder, 2018). Therefore, further work is needed to determine spiritual care practices in order to provide adequate nursing education.

For nurses to provide spiritual care, institutional acknowledgement of the importance of spiritual care is needed. Nurses have highlighted the lack of adequate settings to address spirituality. Spiritual care needs to be a part of the institutional vision to enable the provision of this care to become relevant and accountable by institutions (Epstein-Peterson et al., 2015; Piderman et al., 2015; Sherman et al., 2015).

Nurses who did engage in spiritual care reported significant personal growth and life-changing experiences from having done so. Future research should further explore patient and family perspectives

of spirituality and test ways to best train nurses and all clinicians to provide this care.

4.1. Limitations

This study includes some limitations. For the survey, a convenience sample of nurses in the USA and Switzerland was selected. Most of these nurses had already been working in palliative care environments with exposure to issues of spirituality in cancer patients. Therefore, some educational basis was already present in the sample. Although nurses from two different countries were invited to respond to this survey, cultural differences have not emerged specifically. Further research may be needed with larger samples and a quantitative approach to determine the influence of country-related specificities in nurses providing spiritual care. Discussing spiritual or religious issues involves the right wording. This survey included an English and German speaking sample. Further research may need to focus on issues of wording also in relation to the different languages spoken around the globe.

In this survey, the nurses' perspective was obtained. To better understand the influence of providing spiritual care to patients, further research eliciting patients' responses is needed to provide more adequate responses to patients' needs.

5. Conclusion

Addressing spiritual care in cancer patients remains a sensitive issue. This is the case even though patients appear to ask for this kind of care. Closely listening to patients' expressions may be one way of promoting spiritual/religious care. In addition, as the stories in this survey suggest, addressing spirituality/religion appears to have a beneficial influence on nurses and patients alike. In this survey, spiritual care was described by nurses involving not only religious practices but also drawing on other non-religious or spiritual resources such as meditation practice.

Credit author contribution statement

Maya Zumstein-Shaha: Conceptualization, Methodology, Data curation, Analysis, Writing - original draft, Results section. **Betty Ferrell:** Conceptualization, Methodology, Data curation, Writing - original draft, preparation. **Denice Economou:** Conceptualization, Methodology, Writing - original draft, preparation, Writing - review & editing.

Declaration of competing interest

No conflict of interest is declared by any of the authors.

Acknowledgements

We would very much like to thank Ellen Friedman for collating the data and for handling the international communication as well as editing advice. Thank you also to the contributing survey participants who generously shared their stories.

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